11-5-07

Cost Containment: Identify Health Care Costs/Savings
Health Care Access Commission Working Group
Co-Chairs: Sen. Tony Lourey & Rep. Erin Murphy

Recommendation – Health Care Homes and Management of Chronic Conditions (Priority #1)

A. The Problem

The current health care system inadequately meets the needs of patients. The current payment structure is episode driven and gives providers little or no incentive to monitor the health status of a patient between visits. This system centers on the 'tyranny of the visit', pressures providers to increase volume and see more patients in less time, and values visits and procedural services over coordination and management of chronic conditions by health care providers. For Minnesotans with chronic or ongoing conditions requiring care and treatment, care delivery can be disjointed and fragmented, making self-management much more difficult. Health care providers often have difficulty integrating evolving clinical research, best practices, and guidelines for quality into their practices.

In too many instances, these factors result in underuse, misuse, or overuse of health care services for patients because providers work in a system that does not support their ability to coordinate the care a patient receives for complex health conditions that involve multiple care settings. At the same time, more Minnesotans are uninsured, and those with insurance are faced with rising premium costs and insufficient coverage to meet their health care needs.

B. Goal and Vision Statement

The overall goal of this recommendation is to create a health care system that improves the health and well-being of all Minnesotans, contains costs, and provides better value for our health care dollar. Main components of the recommendation include:

1. Create and support a long-term, stable, and trusting relationship between the patient and his or her health care provider and that provider's team, through a health care home model. The health care home would support and guide the patient through a complex health care system, and provide, arrange for, or coordinate all needed health care and related services as part of a whole-person, integrated approach across all care settings.

2. Assist the patient in participating more fully in decisions about his or her care as part of the care team, provide the patient with better information to make decisions, and encourage, and provide incentives for, healthy patient behavior.

3. As part of a health care home, support the reliable delivery of preventive care and disease management through care coordination, which has been shown to increase health care quality and reduce health care spending. Fundamental changes in the health care reimbursement system, including reallocation of existing spending, are needed to reward providers for providing services that have been shown to be effective and to ensure that it is economically viable for providers to deliver care through a health care home model.

4. Measure and publicly report health care quality, outcomes, and costs, and require providers to meet explicit standards for quality, outcomes, and costs, in order to increase the value received for each health care dollar spent.

There are many pilot and demonstration projects that have incorporated the above elements. The recommendations that follow are an attempt to extend what has been learned from these projects to the broader fee-for-service and managed care systems for state health care program[1] enrollees, and by doing so encourage and strengthen private sector efforts that are based on health care home models.

The working group envisions that, absent new sources of funding, health care savings resulting from use of a health care home model would be used to increase funding for primary care services and other services shown to be effective, and to fund initiatives to reduce and eliminate the number of persons who are underinsured and uninsured.

While we acknowledge that the work of defining exactly what a health care home will look like in Minnesota is not complete, the recommendations that follow are offered with broad support from a diverse and engaged working group of stakeholders from all sectors of the health care system. We anticipate relying heavily on the work of the public-private partnership established in this recommendation to develop the detailed criteria for a health care home model based on evidence, collaboration, and a community consensus.

The working group believes that the health care home model and related care coordination and disease management initiatives can improve quality and value across all types of care – preventive, acute, chronic, and end of life, and across all care settings and patient groups. However, given the nature of the task assigned to our cost-containment working group, our recommendations focus largely on patients with complex and chronic conditions, since it is for this population that cost savings resulting from reduced emergency room and hospital stays and improved coordination of care are most pronounced. It is our sincere intent that the systems designed for the population with chronic conditions be used as building blocks to develop a broader, superior care delivery model for all populations. For example, it would be possible as an initial step to extend health care home and related initiatives beyond state health care program enrollees to those employee groups receiving health care coverage through the Department of Employee Relations.

C. Summary of Recommendation

Expand the use of health care home (some working group members prefer use of the terms patient-centered medical home, medical home, or health home), disease management, and integrated, whole-person care management programs for state health care program enrollees. Establish a public-private health care home partnership to coordinate and support health care home initiatives. Modify state health care program reimbursement to support the use of health care homes, disease management, and integrated care management, and to reward providers for quality care. Provide financial and technical assistance to enable providers to establish and operate health care home, disease management, and integrated care management programs. Build upon, and as necessary expand, the existing information infrastructure to efficiently implement these programs and to measure provider performance and health care quality. Develop and support the primary care provider base necessary to expand the use of health

[1] As used in this document, "state health care program" means the Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs.

care homes, disease management, and integrated care management.

D. Stakeholders

There is general agreement among the stakeholders represented on the working group that the expansion, development, and evaluation of health care home, disease management, and integrated whole-person care management models has the potential to reduce fragmentation of care, increase care coordination and efficiency, and support clinical decision-making. There is further agreement that some innovative local models of health care homes and disease management have improved the quality of care and resulted in cost-savings, and can serve as models for future efforts.

E. Past and Current Efforts

A number of private-sector organizations in Minnesota have implemented or developed health care home, disease management, and integrated whole-person care management efforts. These include the:

- HealthPartners diabetes chronic care improvement program. The program provides evidence-based care for persons with diabetes and has resulted in a reduction in risk-factors, and reductions in amputations, heart attacks, and retinopathy from complications of diabetes. Improved blood sugar, cholesterol, and blood pressure control can result in estimated savings of $500-600 dollars per patient per year.[2]

- St. Mary's/Duluth Clinic chronic disease management program for treatment of diabetes, hypertension, congestive heart failure, and asthma. The treatment module for each chronic condition includes a patient registry, a schedule for appropriate tests, timely follow up, patient compliance, education and support for the patient and family, adherence to ICSI guidelines, and feedback for providers. The program has just begun an analysis of cost-savings.

- DIAMOND Initiative for treatment of depression. The initiative is a collaboration among ICSI, primary care medical groups, DHS, and six health plans. The initiative will include practice redesign based on best practice model components and a payment model that supports the best practice model components. It is expected that implementation will begin in 2008. The long-term goal of the initiative is to create a sustainable care management program that is applicable to other chronic diseases.

- Mayo Clinic efforts to increase the use of primary care physicians by employees. The Mayo program attempts to connect each employee to a personal physician and includes copayments for specialty but not primary care. The program replaced a plan that provided first dollar coverage and open-access to specialists. The program is estimated to have resulted in a ten percent per capita reduction in total health care costs (savings of about $570 per person)[3].

- Park Nicollet CMS demonstration project on care coordination for congestive heart failure. The project would be an evidence-based approach to care delivery for Medicare patients with congestive heart failure, that would include a care management fee for non-reimburseable care management costs for patients (e.g. equipment, patient outreach, registries, oversight, and

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[2] Patrick O' Connor, International Journal for Quality in Health Care, 15:283-285 (2003), as cited in Brian Rank, "Chronic Care Improvement: Diabetes" August 8, 2007 presentation to the Cost Containment: Identify Health Care Costs/Savings working group.

[3] George Schoephoerster and Douglas L. Wood, "Patient-Centered Medical Home" August 14, 2007 presentation to the Cost Containment: Identify Health Care Costs/Savings working group.

assessment and interpretation of data). The project is based on a Park Nicollet congestive heart failure program first implemented in September 2005, that has shown a 61 percent reduction in hospital admissions, estimated annual savings to CMS of $4,680 per patient, and program costs of $125-133 per patient per month.[4]

In addition, the state of Minnesota has recently implemented or authorized a number of efforts related to health care homes and disease management. These include DHS initiatives related to:

- Pay for performance for medical groups and clinics that demonstrate optimum care in serving individuals with chronic disease enrolled in state health care programs.

- A patient incentive program for state health care program enrollees who meet personal health goals established with the patient's primary care provider to manage a chronic disease or condition, including but not limited to diabetes, high blood pressure, and coronary heart disease. The program is to be implemented July 1, 2009, or upon federal approval, whichever is later.

- Patient centered care coordination (previously known as provider directed care coordination) program for clinics serving fee-for-service MA enrollees with complex and chronic medical conditions. Clinics will be required to develop care plans and have a dedicated care coordinator, an adequate number of patients, evaluation mechanisms, and quality improvement processes. The effective date for the authorizing legislation is January 1, 2008.

- Care coordination pilot projects for children and adults with complex health care needs enrolled in MA fee-for-service programs. DHS is authorized to administer up to four pilot projects. Pilot projects must use primary care clinic models that focus on care coordination and family involvement, provide medical homes, and coordinate services across the continuum of care. At least two of the projects must focus on children with autism or children with complex/multiple-diagnoses physical conditions.

- Medical home learning collaboratives administered in conjunction with the Minnesota Department of Health and the Minnesota chapter of the American Academy of Pediatrics. Under the collaborative, teams comprised of a pediatric provider, clinic-based care coordinator, and the parents of two children with special health care needs meet regularly to plan and implement improvements within the context of a medical home model. The collaborative meets regularly to share information, reinforce medical home principles, and plan future improvements. Initial results have shown more effective coordination of care and a significant decrease in the use of expensive services, with the use of preventive services remaining the same or increasing.

- Minnesota Senior Health Options (MSHO) program. Using a care coordination model, MSHO provides a combined Medicare and MA benefit, including integrated prescription drug coverage, as part of a statewide federal demonstration project. Enrollment in MSHO is voluntary.

- Minnesota Disability Health Options (MnDHO) program. MnDHO is a voluntary managed care program for persons with disabilities under age 65 that operates under combined Medicare

[4] Park Nicollet Health Services, Billings Clinic, Geisinger, Marshfield Clinic, and Middlesex Health System, "CHF Care Management Results" (slide presentation) October 2007.

and MA authority. The program provides all Medicare primary, acute, and long-term care services and also includes all prescription drug coverage under one plan. The program currently operates in the seven-county metropolitan area.

F. Details of Recommendation

1. Establish a public-private health care home partnership. Establish a public-private health care home partnership to develop measurement, cost, and quality standards and other criteria for health care home providers, integrated care management programs, and disease management programs for chronic conditions. The chronic conditions would include, but are not limited to, depression, congestive heart failure, hypertension, diabetes, asthma, and coronary artery disease.

The partnership would be comprised of representatives of MDH, DHS (represented by the medical director), the Institute for Clinical Systems Improvement (ICSI), Minnesota Community Measurement, health care providers, patients, payors, and other entities. MDH would be the lead agency and would convene the partnership and provide administrative and technical support. MDH would ensure that those appointed have expertise in: health care delivery; health care payment and financing; measurement of costs, quality, and outcomes; and health care policy and administration.

This partnership, or a similar entity, could be used to make decisions about basic benefit package design, health care coverage, technology assessment, and broader health care measurement issues.

2. Develop criteria for health care home providers. The health care home partnership would designate providers meeting specified criteria, that are willing to work towards health care home goals and objectives, as health care home providers. These providers would be eligible to receive reimbursement as health care homes. Providers would not be required to become health care homes.

The criteria would be based on the principles described in "Joint Principles of the Patient-Centered Medical Home" March 2007, developed by the American Academy of Family Practice, American Academy of Physicians, American College of Physicians, and the American Osteopathic Association, as modified to emphasize the role of a team of primary care providers, patient participation, and measuring and holding providers responsible for the quality of care. The principles include:

a. Each patient has an ongoing, long-term relationship with a primary care provider trained as a personal clinician to provide first contact, continuous, and comprehensive care. Appropriate specialists and other health care professionals who do not practice in a traditional primary care field can also serve as personal clinicians, if they provide care according to the health care home model and accept responsibility for outcomes.

b. Care is provided by an interdisciplinary team of individuals who collectively take responsibility for the ongoing care of patients. The health care home is not a place but a model of coordinated care.

c. The personal clinician and the team is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, as part of a whole-person orientation. This includes care for all stages of life – preventive care, acute care, chronic care, and end of life care. Ideally, the primary care team would also be responsible for providing for, or arranging to meet, the social service needs of the individual, if this is necessary to ensure a successful health outcome.

d. The patient is expected to actively participate in decision-making and quality improvement, as a full member of the primary care team. Health care homes should support and promote the active participation of patients in decision-making.

e. Care is coordinated across all provider types, all care locations, and the greater community. Care is facilitated by systematic follow-up, information technology, health information exchange, and other methods. Care is provided in a culturally and linguistically appropriate manner.

f. Quality and safety benchmarks should be hallmarks of the health care home. Key elements include provider advocacy on behalf of patients, use of evidence-based medicine and clinical decision-support tools, continuous quality improvement, and use of information technology. The health care home should provide care that is consistent with the six aims identified by the Institute of Medicine – care that is safe, timely, effective, efficient, equitable, and patient-centered.[5]

g. Enhanced access to care through open scheduling, expanded hours, and new communication methods (e.g. e-mail, phone consultations, e-consults).

h. The payment structure recognizes the value provided by a redesigned care experience in a health care home. The payment structure should allow flexibility, so that current dollars can be used for care management that is provided outside of a face-to-face visit, services associated with the coordination of care, support of the use of health information technology for quality improvement, enhanced communication through e-mail and phone consultation, remote monitoring of clinical data, and separate payments for face-to-face visits. The payment model should recognize differences in patient case mix, allow primary care providers to share in savings from reduced hospitalizations and emergency room visits, and support continuous quality improvement.

i. The performance and health outcomes of health care home providers is monitored, measured, and publicly reported, and providers are required to meet specified outcome and quality standards in order to be considered a health care home.

Basic criteria would apply to all health care home providers. Additional criteria would apply to providers treating patients with specified chronic conditions and providers operating integrated care management programs.

3. Encourage state health care program enrollees to select a personal clinician. DHS would encourage, but not require, state health care program enrollees to select a personal clinician. DHS or county agencies would provide enrollees with lists of providers, and would assist enrollees with complex or chronic conditions in choosing an appropriate provider. This information would also be available through a 1-800 number and on the web. Enrollees would be given incentives to choose a personal clinician, and additional incentives to choose a personal clinician who meets health care home criteria or provides disease management or integrated care management appropriate for the enrollee's

[5] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century" Report Summary, March 2001.

condition. Providers would be given incentives to implement outreach efforts to encourage recipients to choose a personal clinician.

4. Provide state health care program enrollees with education and outreach related to primary care. DHS would provide patient education and outreach to state health care program enrollees related to preventive and primary care, and the importance of choosing a primary care provider. Education and outreach could be targeted to underserved or special populations.

5. Develop the infrastructure to support health care homes and disease management. The health care home partnership would identify appropriate, existing methods for systematic follow-up for certain diseases. The partnership would develop follow-up systems for specific chronic conditions only if a suitable system to support the health care home in providing longitudinal care does not already exist.

MDH, in consultation with the health care home partnership, would support the development and maintenance of an appropriate information and technology infrastructure. The infrastructure must be interoperable to the greatest extent possible and must be consistent and coordinated with existing provider and health plan information and technology requirements, so that duplicative processes are not created. A health care home would not be required to maintain a separate electronic medical record system for health care home patients. MDH would provide technical and financial support to providers to develop health care homes.

6. Develop the ranks of primary care providers participating in the health care home. In view of the "age wave" and the expected increase in the demand for care, providers would work in interdisciplinary teams and to the top of their license, utilizing primary care providers fully to meet growing health care needs. In order to meet this increased demand for primary care providers, the state should:

- Invest in the educational preparation of primary care providers (see the separate recommendation on expanding the supply of primary care providers); and

- Consider the overlapping scopes of practice for licensed providers and eliminate unnecessary barriers in regulation, law, and reimbursement methodologies, to increase the number of primary care providers while continuing to improve the safety, quality, and experience of patient care.

7. Monitor and evaluate health care home providers. MDH, in consultation with the health care home partnership, would ensure the collection from health care home providers of any data necessary to monitor implementation of health care homes and disease management and integrated care management programs, evaluate quality of care and outcomes, evaluate patient experience, and determine provider and health plan savings. MDH could collect and evaluate this data directly or through contract with an appropriate private-sector entity.

8. Develop a new health care home reimbursement system. DHS, in consultation with the health care home partnership, would study and develop a new fee-for-service health care home reimbursement methodology for MA and an appropriate fee-for-service risk adjustment mechanism, and report to the legislature by January 15, 2009. The report must include recommendations on the extent to which the new reimbursement methodology and risk-adjustment mechanism should also be applied to state managed care programs.

Implementation of the new system would begin July 1, 2010. In developing the model, DHS would consider existing proposals for health care home reimbursement, including but not limited to existing private sector initiatives, the results of health care home-related demonstration projects implemented by DHS and MDH, primary care case management initiatives of other states, and the Advanced Medical Home reimbursement methodology proposed by the American College of Physicians (ACP)[6].

The ACP methodology has the following components:

a. A prospective, bundled, risk-adjusted practice component to cover practice expenses related to the health care home model (enhanced access and communication, population management and systematic follow-up, tracking of patient medical data and referrals, provision of evidence-based care, health information technology, and reporting).

b. A prospective, bundled, risk-adjusted care coordination component that recognizes services that fall outside the face-to-face visit (care plan oversight, e-mail and telephone consultations, extended patient medical data review, and physician supervision of self-management education)

c. A visit-based, fee-for-service payment.

d. A performance-based payment tied to meeting quality and efficiency goals.

DHS, and MDH when appropriate, would evaluate current state health care home-related demonstration projects, and use available results when developing the new health care home reimbursement system.

9. Require managed care plans serving state health care program enrollees to adopt the basic health care home model. Managed care plans, as a condition of contract, would be required to adopt the basic health care home criteria developed by the health care home partnership, beginning July 1, 2009. DHS would have authority to waive certain health care home criteria, if DHS determined that a plan would still meet health care home performance and quality standards. DHS would collect from plans any data necessary to monitor implementation, measure quality, and determine plan savings.

Savings from the use of health care homes would be split among the state, the providers, and the managed care plan, as part of the annual rate negotiation process, or through an annual settle-up. DHS would provide a performance incentive for expenses related to the operation of health care homes, with up-front costs reimbursed after a one-year lag, rather than the normal two-year lag.

10. Require managed care plans serving state health care program enrollees to operate one or more disease management programs for enrollees with chronic health conditions, or an integrated care management model. Managed care plans, as a condition of contract, would be required to provide care for one or more specified chronic conditions using a health care home disease management model or provide care through an integrated, whole-person care management model, beginning July 1, 2009. The models must meet criteria specified by the health care home partnership. DHS would have authority to waive certain disease management criteria, if DHS determined that the

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[6] American College of Physicians, "A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care" A Position Paper of the American College of Physicians, 2006.

program would still meet performance and quality standards. The chronic conditions would be those identified by the health care home partnership, but DHS would have the authority to approve health plan-specific disease management programs for additional chronic conditions. DHS would collect from plans any data necessary to monitor implementation, measure quality, and determine plan savings, and report information on implementation, quality, and plan savings to the legislature.

Savings from the use of disease management and integrated care management would be split among the state, the providers, and the managed care plan, as part of the annual rate negotiation process, or through an annual settle-up. DHS would provide a performance incentive for expenses related to the operation of disease management and integrated care management programs, with up-front costs reimbursed after a one-year lag, rather than the normal two-year lag.

The commissioner, in consultation with the health care home partnership, would specify quality standards for disease management and integrated care management programs, and these standards would be subject to a capitation rate withhold.

11. Create transparency and accountability among DHS, health plans serving state health care program enrollees, and the legislature. DHS would annually report to the legislature the rates and other financial arrangements established with health plans serving state program enrollees, and estimates of savings obtained from implementation by health plans of health care homes, disease management, and integrated care management. If these health plans are unable to implement integrated care management or disease management programs through a health care home for state health care program enrollees, enrollees with chronic conditions shall be transferred from managed care to fee-for-service health care homes.

G. Estimated Cost/Savings

Agency and legislative staff are working on cost and savings estimates for the recommendation.

H. Limitations

The implementation of health care home models and reimbursement systems to support these models is in its infancy. Some existing models that show promise have only recently been implemented and studies of the effectiveness of the models and resulting cost savings have not been completed. Another possible limitation is the need to invest in the information infrastructure and to increase reimbursement for health care home-related services, prior to the realization of cost savings from implementation of the model. It is also difficult to determine and quantify savings under managed care programs for state health care program enrollees. There is also a need to ensure continuity of care for state health care program enrollees, due to individuals moving on and off programs due to changes in eligibility, and moving between different providers and health plans while covered. Finally, implementation and expansion of the health care home model will require some reallocation of existing funds within the current health care system.

I. Additional Preliminary Recommendation

Establish a collaborative process and public-private partnership to assess new health care technologies and procedures. The working group recommends that the Health Care Access Commission, or another relevant entity, study the potential for this approach to reduce health care costs by establishing guidelines as to when the use of certain technologies and procedures is appropriate.

This approach may also help to re-balance the health care system in favor of primary care and care coordination. The working group discussed but did not have time to pursue this proposal.

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Cost Containment: Identify Health Care Costs/Savings
Health Care Access Commission Working Group
Co-Chairs: Sen. Tony Lourey and Rep. Erin Murphy

Recommendation – Expand the Supply of Primary Care Providers (Priority #2)

A. Summary of Recommendation

Expand the supply of primary care providers in rural and underserved areas of the state. The goal of this recommendation is to expand access to primary care services, reduce disparities in access to services, improve health care quality, and reduce health care costs. These recommendations would also expand the supply of primary care providers for health care home and disease management initiatives and allow primary care teams to function more effectively within the health care home model (see separate recommendation on health care homes).

B. The Problem

The availability of primary care providers is expected to decline in the near future, and the number of new students entering primary care is decreasing. In addition, primary care physicians are leaving the field in disproportionate numbers. The American College of Physicians notes that this will result in "further fragmentation of care and lead to poorer quality, more inefficiencies, and higher health care costs."[1]

Patients with a regular generalist physician have lower overall costs than patients without one. Increased ratios of primary care physicians relative to the population are associated with reduced hospitalization rates for six ambulatory care-sensitive conditions. Health care costs have been found to be higher in regions of the U.S. with higher ratios of specialists to the population.[2]

Within Minnesota, there is a geographic imbalance in access to primary care physician services. The number of primary care physicians per 100,000 people is 129 in metropolitan counties, 98 in micropolitan counties (rural areas with a population center of 10,000 to 50,000), and 75 in rural counties. The 46 most rural counties in Minnesota have 13 percent of the state's population, but just five percent of the state's practicing physicians.[3]

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[1] American College of Physicians, "A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care" Position Paper, 2006.
[2] Thomas Bodenheimer et al. "The Primary Care Specialty Income Gap: Why it Matters" Annals of Internal Medicine vol. 7, no. 4, February 20, 2007, pp. 301-306.
[3] Minnesota Department of Health, Office of Rural Health and Primary Care, "Minnesota's Physicians Facts and Data 2006" and "Workforce Challenges and Opportunities in Rural Minnesota: Who's Going to Staff the Medical Home?" Presentation to the Cost Containment: Identify Health Care Costs/Savings Working Group, September 18, 2007.

C. Stakeholders

There is general agreement among the stakeholders represented on the working group that expanding the number of primary care providers in rural and underserved areas would improve quality of care, reduce health care costs, and ensure a sufficient supply of primary care providers to implement health care home initiatives.

D. Past and Current Efforts

The legislature and state agencies have recognized the need to increase the supply of health care providers in rural and underserved areas, and over the years have authorized and implemented a number of initiatives. These initiatives include:

- establishment of the Office of Rural Health and Primary Care within the Minnesota Department of Health (MDH);
- loan forgiveness programs administered by MDH for: (1) physicians who practice in designated rural areas or underserved urban communities, or specialize in pediatric psychiatry; (2) physician assistants and advanced practice registered nurses who practice in designated rural areas or teach nursing in a postsecondary program; (3) nurses who practice in a long-term care facility or teach nursing in a postsecondary program; (4) certain health technicians who teach in their designated field in a postsecondary program; (5) pharmacists who practice in designated rural areas; and (6) dentists who serve a specified percentage of public program clients;
- provision of funding to the University of Minnesota to increase the number of medical school graduates who practice primary care by 20 percent over an eight-year period, establish a rural residency training program in family practice, and implement other primary care initiatives;
- summer intern and health careers programs, administered by MDH; and
- establishment of the Health Education Industry Partnership, administered by Minnesota State Colleges and Universities (MnSCU), to identify and address critical healthcare workforce shortages.

E. Details of Recommendation

1. Expand funding for primary care and rural physician training initiatives at the University of Minnesota and the Mayo Medical School, to allow these institutions to increase the number of graduates of residency programs who practice primary care by 20 percent over an eight-year period. This proposal expands statutory provisions passed in the early 1990's that provided for a 20 percent expansion in primary care graduates at the University of Minnesota Medical School and authorized related initiatives (see M.S. § 137.38 to 137.40).

Expand funding for primary care Advanced Practice Registered Nurse (APRN) training initiatives to allow schools of nursing in Minnesota to increase the number of graduates of APRN programs by 20 percent over an eight-year period.

2. Expand funding for an existing health care professional loan forgiveness program administered by MDH (see description of program in previous section).

3. Provide funding to the University of Minnesota, the Mayo Medical School, and Minnesota schools of nursing, to address faculty shortages in primary care medicine and nursing.

4. Require MDH to explore the feasibility of the "community paramedic" concept for Minnesota, with comparative analysis of this role and the role of the Community Health Worker, and present recommendations to the legislature by January 15, 2009. This concept would use paramedics and emergency medical technicians (EMTs) to deliver preventive and some primary care. MDH would examine issues related to the preventive and primary care services that could be provided, quality of care, curriculum development, and possible pilot project implementation.

5. Require MDH to explore methods of better integrating pharmacists into the primary care team, and report recommendations to the legislature by January 15, 2009. MDH would study existing models of using pharmacists to conduct medication reviews and medication therapy management, and in conjunction with DOER, evaluate the medication therapy management program being pilot tested for certain state employees.

6. Require MDH to review existing statutory and regulatory licensure requirements, and practice limitations created by different licensure levels, to identify situations in which clinicians in a primary care setting could provide an expanded level of care to patients, thereby increasing access to primary care services. MDH would report recommendations to the legislature by January 15, 2009.

F. Estimated Costs/Savings

Agency and legislative staff are working on cost and savings estimates for the recommendation. The cost of items 2 and 3 will depend on the amount of funding made available by the commission.

G. Limitations

Implementation of the recommendation will not lead changes in the supply of primary care providers in the short-run, given the time needed to expand education programs and for health care providers to graduate from a course of study. It would also take time for MDH to study the issues required under items 4 through 6, and for the legislature to pass any necessary legislation.

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